CORE COMPETENCIES OF SERVICE PROVIDERS:

VIEWS OF CONSUMER STAKEHOLDERS

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EMPOWERMENT

- Encourage the consumer's independent thinking.
- Treat the consumer like they believe (s)he can shape his/her own future.
- Give the consumer freedom to make his/her own mistakes.
- Support choice-making and risk-taking as leading to growth.
- Understand and support the consumer's need to regain "critical consciousness" or self-awareness.
- Learn how to provide choice and avoid controlling behaviors.

COMMUNICATION SKILLS

- Listen to the consumer and believe what (s)he says.
- Learn to practice the strengths model.
- Look at and recognize the consumer's abilities.
- Learn to compliment consumers respectfully on their abilities.
- Learn to listen to consumers and consider what they say to be valid and important.
- Learn how to talk to the consumer when they need to talk to someone.

SELF-MANAGEMENT

- Learn how consumers live with and manage their disorders.
- Learn about and support consumer self-control of psychotic symptoms.
- Learn and support the coping strategies of consumers, as well as recognize stressors.
- Learn how to accept consumers' feelings of sorrow, despair, anger, frustration, joy, excitement, etc. without pathologizing.

RECOVERY ATTITUDES

- Treat the consumer in a way that helps the recovery process.
- Learn recovery triggers and structure settings so recovery triggers are present.
- Believe in the consumer's ability to recover.
- Learn to foster a sense of hope.
- Shift from a stance of demoralizing pessimism to rational optimism.
- Learn to break the cycle of dis-empowerment, despair and learned dependency.

RECOVERY TECHNIQUES

- Learn how to reduce symptoms and distress according to the perceptions of the consumer. Explore and understand feelings, thoughts, values, goals and roles that enhance recovery throughout treatment.
- Learn to assist people to be successful and satisfied in chosen roles and settings. Minimize reliance on crisis intervention.
- Learn to access services that facilitate recovery through case management.
- Learn shared decision-making techniques and models of clinician-client partnership. This is particularly important in maintaining medication schedules.

STIGMA

- Learn to respect people's dignity by taking into account their status as survivors of the mental health system and of physical and sexual violence, as well as their cultural and ethnic diversity, including sexual orientation.
- Learn about how much psychiatric labels and language can stigmatize and diminish people.
- Learn not to treat consumers as children.
- Learn to avoid stigmatizing language.
- Learn that recovery from the consequences of the illness are sometimes more difficult than recovering from the illness itself. Issues of dysfunction, disability, and disadvantage are often more difficult than impairment issues.
- Learn methods to support community interaction with consumers.
- Learn that an inability to perform valued tasks and roles, and the resultant loss of self-esteem, are significant barriers to recovery.

IATROGENIC EFFECTS

- Understand the negative outcomes of coercion in treatment settings.
- Learn to mitigate the negative consequences of coercion by attending more closely to procedural justice issues (fair decision-making process) and supporting consumer voice, validation, respect, and information.

VIOLENCE

- Learn the statistics related to mental illness and violence and recognize that people with mental illness are not usually dangerous.
- Learn non-violence responses to consumer threats and violence.
- Learn alternatives to seclusion and restraints, including mediation.
- Learn ways to avoid involuntary commitment by addressing problems before they escalate.

TRAUMA

- Learn the signs and impacts of sexual and physical trauma.
- Recognize the trauma induced by the mental health system with particular attention to re-traumatizing effects of over-medication, and the use and abuse of seclusion and restraints.

SERVICE PLANNING

- Coordinate and structure services to enhance the total well-being of the consumer, rather than offer isolated programs that address individuals' deficits, or programs that specialize in only a segment of one's well being.
- Learn how to build choice into service planning.
- Treat the consumer as an equal in planning his/her services.
- Training and support for consumers to become real participants in developing individual service plans. Work with the consumer to find the resources (s)he needs.
- Assess if consumer problems and needs are consumer identified/defined or professionally identified/defined.
- Resource allocation to "black box" programs need to be minimized and replaced with individualized services that contribute to a consumer's progress toward recovery.

VOCATIONAL SKILLS

- Learn to provide prevocational and vocational skills training. Learn the "choose-find-keep" model of job placement--job development and placement should be based on the expressed need and demonstrated interest of consumers.

RELAPSE AND CRISIS

- Learn not to penalize consumers for relapses.
- Learn that the episodic nature of severe mental illness does not prevent recovery.
- Learn how recovery changes the frequency and duration of symptoms.
- Learn that recovery is not a linear process, but involves growth and setbacks, periods of rapid change and little change.
- Learn non-threatening crisis response techniques.

MEDICATIONS

- Teach the consumer about the medications (s)he is taking.
- Learn to use the consumer as the expert on what medications work and do not work.
- Learn to recognize the subtle and severe side-effects of medications.
- Rather than support a program of medication compliance, support informed judgment of consumers by enabling them to learn what they are really like off medications.

EDUCATION

- Educate consumers about their diagnosis, prognosis, medications, and treatment.
- Set up training programs to teach consumers how to work with the local mental health board and the mental health system.
- Learn and teach consumers about advance directives.
- Learn and then provide training for consumers in how to work effectively with human service systems, and how to access benefits.

SELF-HELP

- Support for self-help groups and enable consumers to access alternative supports.
- Support consumers helping other consumers recover.
- Learn about spiritual alternatives.
- Learn about and then educate consumers on the history and organization of the consumer movement.

RIGHTS

- Learn about consumer rights.
- Learn all protocols regarding privacy and confidentiality of consumer data.
- Learn the provisions of the ADA and the manifestations of discrimination.
- Learn about informed consent protocols, and how to provide informed consent for all treatment and data collection activities.

Annotated Bibliography

- Beale, Velma & Lambric, Tom. (1995). The Recovery Concept: Implementation in the Mental Health System: A Report by the Community Support Program Advisory Committee. Ohio Department of Mental Health. This document can serve as an educational tool on the concept of recovery for professionals, families and consumers themselves. As the system moves towards managed care, the recommendation reported by the CSP Advisory Committee to develop a recovery model of treatment for consumers is essential. This report can be used as part of a strategic step forward beyond a few consumer controlled "alternatives" to a recovery oriented system. Excellent. R1
- Brier, Alan & Strauss, John (1983). Self-control in psychotic disorders. Archives of General Psychiatry 40, p. 1141-1145. This research article establishes that through the

use of self-control measures, many persons with psychotic disorders are able to exert control over symptoms. This self regulation process consists of three phases: (1) persons become

aware of the existence of psychotic or prepsychotic behavior by self monitoring; (2) the person recognizes the implications of these behaviors as a signal of the disorder; (3) mechanisms of self-control are employed, including self-instruction, reduced involvement in activity, and increased involvement in activity. Very important work. R1

- Campbell, Jean & Schraiber, Ron. (1989). The Well-Being Project: Mental Health Clients Speak for Themselves. California Department of Mental Health. The watershed consumer-directed services research project that relied entirely on consumers/survivors from inception to dissemination of findings. Analysis of 500 responses established the intrinsic link between well-being and personhood. Rather than focusing on pathology and disability, the respondents reported the same needs as most citizens, including freedom. Clinical attitudes and behaviors had the greatest negative effect on well-being with basic freedom and choice, consumer voice, validation, respect and information key variables. Other topics included help-seeking behaviors and coping strategies. A wealth of key information that is organized alphabetically for easy reference. R1
- Chamberlin, Judi. (1978). On Our Own: Patient-Controlled alternatives to the Mental Health System. Hawthorne Books: New York. The classic book of the psychiatric liberation movement that propelled mental health consumer to become actively involved in their services and to develop peer-run alternatives to traditional mental programs. A comprehensive critique of the biomedical model that is as relevant today as when it was first published. A must read by all mental health staff. R2
- Davidson, Larry & Strauss, John. (1995). Beyond the biopsychosocial model: integrating disorder, health, and recovery. *Psychiatry* 58, p. 44-55. The authors reconsider traditional models of disorder and suggest that the focus on pathology and led to the exclusion of processes of health and recovery. They develop a life-context model to permit a more effective integration of the diverse factors involved in the restoration of health. They present such concepts as the coexistence of competence and dysfunction as underlying the core rehabilitative strategy of building on a patient's strengths. An intellectual tour de force on recovery. R2
- Deegan, Patricia. (1996). Recovery as a journey of the heart. *Psychiatric Rehabilitation Journal* 19(3), p. 91-97. The author discusses both the concept, goals, and process of recovery using her own experiences to illuminate her observations. She cites hope as particularly important and the behaviors and attitudes of staff that erode a person's ability to care. The article sets the goals of a training agenda for the next generation of mental health professionals. R1
- Herman, Judith. (1992). Trauma and Recovery. Basic Books. This book represents the fruits of two decades of research an clinical work with victims of sexual and family violence. It also reflects a growing body of experience with many other traumatized people. This is a book about restoring connections: between public and private worlds, between the individual and the community, between men and women. It defines the fundamental stages of recovery: establishing safety, reconstructing the trauma story, and restoring the connection between survivors and their community. The second part of the book develops an overview of the healing process and offers a new conceptual framework for psychotherapy with traumatized people. Testimony of survivors and case examples are offered. R1
- Lidz, Charles; Hoge, Steven; Gardner, William; Bennett, Nancy; Monahan, John; Mulvey, Edward; & Roth, Loren. (1995). Perceived coercion in mental hospital admission: pressures and process. *Archives of General Psychiatry* 52, p. 1034-1039. This study looks at the determinants of patients' perceptions of coercion and suggests that these perceptions in psychiatric hospital admissions affect their attitude toward subsequent treatment, including their inclination to adhere to treatment plans. Perceptions of being respectfully included in a fair decision-making process such as respect, validation, voice,

and other related aspects of the interaction were most closely associated with perceived coercion. A significant relationship was also found with perceived negative pressures, i.e.,

force and threats. Such findings strongly suggest that clinicians would be well advised to attend to the manner in which they admit patients, especially those admitted involuntarily. R1

- Nide, Nancy (Ed.). (1990). Yes, I Can! Seven True Stories of Persons Coping with Mental and Emotional Illness. Alliance for the Mentally Ill: Franklin County, OH. This anthology of stories of people coping with mental illness has much to offer to an understanding of healing and recovery: e.g., the chapter by Mary Lee Stocks talks of the hypervigilence of co-workers (mental health professionals) who constantly monitored and pathologized her normal range of emotions from joy to anger. This led to her alienation and isolation at work. R2
- Pritchard, Marietta (Ed.). (1994). Dare to Vision: Shaping the National Agenda for Woman, Abuse and Mental Health Services. Proceedings. Human Resources Association of the Northeast: MA. This conference exposed the powerful connection between women's experiences with physical and sexual abuse and the health and mental health damage left in its wake. It discussed the injuries caused by lack of recognition, indifference, and wrong-headedness of caregivers in the mental health system. Conference participants gave grim testimony to the pervasive and long-lasting impact of such treatment, as well as the ways in which the system retraumatizes abuse survivors. Important statistics are also included. R1
- Wells, Donn. (1992). Management of early postdischarge adjustment reactions following psychiatric hospitalization. *Hospital and Community Psychiatry* 43(10), p. 1000-1004. Psychiatric patients frequently experience serious symptoms and demonstrate disturbed behaviors in the early postdischarge period. The author reviews symptoms and behaviors that can occur and notes that they should most often be viewed as adjustment reactions rather than as exacerbations of the primary illness. Interventions and supports are discussed. R2